1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06712 Reg. Dist. No. 06698

1. PLACE OF DEATH
a. COUNTY: HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JOPPA
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 409 Old Philadelphia Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JOPPA
d. STREET ADDRESS: 409 Old Philadelphia Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARL Middle AUGUST FRANK Last ANDERSON
4. DATE OF DEATH: Month MAY Day 17 Year 1967
5. SEX: M
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT 5, 1905
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Pipe Shop
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt-Ret.
11. BIRTHPLACE (State or foreign country): Joppa, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carl A. Anderson
14. MOTHER'S MAIDEN NAME: Barbara Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: 220-20-7276
17. INFORMANT Address: DOROTHY ANDERSON (WIFE)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO (b): ___
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): ___

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. NS
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W Heuman M.D. — MAY 17, 1967 DATE SIGNED
EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 20, 1967
22c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran Cemetery
22d. LOCATION (City, town, or county): Joppa (State): Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
24a. REC'D BY REGISTRAR DATE: MAY 19 1967
24b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1H (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06713

CERTIFICATE OF DEATH

06699

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFord Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 400 South Main Street ~~RD Bailys Alley~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: GRACE — Middle: MADELINE — Last: Bailey

4. DATE OF DEATH: Month: MAY — Day: 13 — Year: 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 1, 1921
9. AGE (In years last birthday): 46 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (County & State, or foreign country): Md. (Harford Co.)
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: W. SANNER BAILEY
14. MOTHER'S MAIDEN NAME: Hattie Viola Preston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-12-9257
17. INFORMANT (Brother) 838-6326 Address: Mr. Tom Bailey — 12 Forest Drive Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemic Shock — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Gram-Negative Bacteria + Enteritis — 8 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Lacunes Cerebri (2) Dehydration + hypokalemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 12, 1967, to May 13, 1967 that (I) (we) last saw the deceased alive on May 13, 1967, and that death occurred at 1230 P M, from causes and on the date stated above.

22a. SIGNATURE: Edward Lee M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/13/67
22c. PHYSICIAN'S NAME (Type): Edward C. Lee, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co, Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a. REC'D BY REGISTRAR — DATE: 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

(Original-State)

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06714

CERTIFICATE OF DEATH

06700

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 124 Wilson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLA — Middle: Josephine — Last: BROWN

4. DATE OF DEATH: Month: MAY — Day: 27 — Year: 1967

5. SEX: female

6. COLOR OR RACE: W

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: AUG. 28, 1902

9. AGE (In years last birthday): 64 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): MASS.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: WILLIS JACOBS

14. MOTHER'S MAIDEN NAME: GEORGIANA BOYD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-46-9262

17. INFORMANT: Mr. FOREST E. BROWN — Address: 124 WILSON ST. HAVRE DE GRACE MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

DUE TO (b): Arteriosclerotic Cardiovascular disease — 3 yrs.

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/24, 1967 to May 27, 1967 that (I) (we) last saw the deceased alive on May 27, 1967, and that death occurred at 1:10 P.M., from causes and on the date stated above.

22a. SIGNATURE: Lloyd Coons M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 5/29/67

22c. PHYSICIAN'S NAME (Type): Edward Coons, M.D.

22d. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 31, 1967

23c. NAME OF CEMETERY OR CREMATORY: HARFORD MEMORIAL GARDENS

23d. LOCATION (City or Town) (County) (State): HARFORD Co. MD.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE MD

25a. REC'D BY REGISTRAR DATE: JUN 1 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06715 — 06701

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 16 hrs 45 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood Arsenal
d. STREET ADDRESS: 6201 C Baker Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lisa — Middle: (none) — Last: CLARK
4. DATE OF DEATH: Month: May — Day: 17 — Year: 1967
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1967
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours: 16 — Min.: 45
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): Harford, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Roosevelt Clark
14. MOTHER'S MAIDEN NAME: Minnie R. Bottoms
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): N/A — (If yes give war or dates of service): N/A
16. SOCIAL SECURITY NO.: N/A
17. INFORMANT: Mother — Address: (Same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 16 hrs 45min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ~~I~~ (this hospital) attended the deceased from 16 May, 19 67, to May 17, 19 67 that ~~I~~ (we) last saw the deceased alive on May 17 19 67, and that death occurred at 12:55 AM, from causes and on the date stated above.

22a. SIGNATURE: Thomas J. Green — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 17 May 1967
22c. PHYSICIAN'S NAME (Type): THOMAS J. GREEN, CPT, MC
22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 19, 1967
23c. NAME OF CEMETERY OR CREMATORY: A.P.G. Post Cemetery
23d. LOCATION (City or Town) (County) (State): Aberdeen Proving Ground, Md.
24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Lee A. Patterson & Son, Perryville, Md.
25a. REC'D BY REGISTRAR DATE: MAY 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06716

CERTIFICATE OF DEATH

06702

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen 12.1
d. STREET ADDRESS: 44 Fenway St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maria — Middle: F. — Last: Copeland
4. DATE OF DEATH: Month: May — Day: 16 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-12-22
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Air Force Exchange
11. BIRTHPLACE (County & State, or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Brown
14. MOTHER'S MAIDEN NAME: Josephine Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 231-22-3346
17. INFORMANT: Mr. John E. Copeland, Aberdeen Md. — Address: 44 Fenway St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
4201
DUE TO
(b): Hypertensive Cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): Coronary Thrombosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 12, 1966 to May 16, 1967 that (I) (we) last saw the deceased alive on May 16 1967, and that death occurred at 10:30 A M, from causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/16/67
22c. PHYSICIAN'S NAME (Type): George T. Stansbury
22d. ADDRESS: 569 Revolution St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Christian Cem.
23d. LOCATION (City or Town) (County) (State): Holland Virginia

24. FUNERAL DIRECTOR: Elmer E. Bullock — ADDRESS: 556 Lewis St Havre de Grace Md.
25a. REC'D BY REGISTRAR — DATE: MAY 22 1967
25b. REGISTRAR'S SIGNATURE: N. Charles Yingst

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06717

CERTIFICATE OF DEATH

06703

1 PLACE OF DEATH
a COUNTY HARFORD MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air
c LENGTH OF STAY IN 1b 1 yr. 2 mo.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Convalescing Home

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE Maryland b COUNTY Harford
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Bel Air
d STREET ADDRESS 404 Giles Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First IRIS Middle V. Last GILLIM
4 DATE OF DEATH Month MAY Day 17 Year 19 67

5 SEX Female
6 COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH Dec. 1, 1880
9 AGE (In years last birthday) 86 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b KIND OF BUSINESS OR INDUSTRY --
11 BIRTHPLACE (County & State or foreign country) Harford County, Md.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME James Kyle
14 MOTHER'S MAIDEN NAME Annie Bird

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)
16 SOCIAL SECURITY NO. 220-54-9070-T
17 INFORMANT Mrs. Flossie V. Hooper Address Bel Air, Md. 404 Giles St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Cerebral hemorrhage, terminating — INTERVAL BETWEEN ONSET AND DEATH 5 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c) Chronic Hypertensive ASCVD — ?

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/14/ , 1956, to 5/17 , 1967, that (I) (~~WAS~~) last saw the deceased alive on 5/16/ 1967, and that death occurred at 10 a.M, from causes and on the date stated above

22a. SIGNATURE Willard P. Hudson MD ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED 5/18/1967
22c PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.
22d. ADDRESS Forest Hill, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF May 19, 1967
23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens
23d LOCATION (City or Town) Bel Air (County) Harford (State) Md

24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009
ADDRESS
25a RECD BY REGISTRAR DATE MAY 19 1967
25b REGISTRAR'S SIGNATURE [illegible] Judge

1

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36715

CERTIFICATE OF DEATH

06704

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1 PLACE OF DEATH
a. COUNTY: Hanford — Md MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN: 3 weeks

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: 3807 Fleetwood — b. COUNTY: Balti.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: 421 S Union St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brevin

3 NAME OF DECEASED (Type or print): First: Charlotte — Middle: Annie — Last: Cundiff

4 DATE OF DEATH: Month: 5 — Day: 18 — Year: 1967

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
F	W	☒ MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED	3-9-1893	74 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Housewife	Home	Knoxville Tenn	U.S.A.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Wm C Sheen	Janet [illegible]

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	Address
	214-10-2428	Brevin	421 S Union St

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebro-Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b): Arterio Sclerotic Syndrome
DUE TO
(c): Hiatus Hernia

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 4/4/, 19--, to 5/15/, 19--, that (I) (we) last saw the deceased alive on 5/17/, 19--, and that death occurred at 1 P M, from causes and on the date stated above.

22a SIGNATURE: [signature] M.D — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 5/18/67

22c. PHYSICIAN'S NAME (Type)

22d ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5 22 1967	Parkwood Cem.	Pittsburgh Pa.

24 FUNERAL DIRECTOR: [illegible] funeral Home — ADDRESS: 940 Ridge Ave (76)

25a. REC'D BY REGISTRAR DATE: MAY 23 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial transit permit. Then please remit [illegible] urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06713 — 06705

1 PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 240 Bloomsbury Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: David — Middle: R[illegible] — Last: Curry

4 DATE OF DEATH: Month: MAY — Day: 6 — Year: 1967

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8 DATE OF BIRTH: Mar. 11, 1911

9 AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOILER FIREMAN
10b KIND OF BUSINESS OR INDUSTRY: DISABILITY

11 BIRTHPLACE (County & State, or foreign country): MD.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: GEORGE A. CURRY

14 MOTHER'S MAIDEN NAME: SARAH JANE MORRIS

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service):

16 SOCIAL SECURITY NO: 214-18-3970

17 INFORMANT: Mrs. Lottie M. Curry — Address: HAVRE DE GRACE, MD.

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO (b): MYOCARDIAL INFARCTION — HOURS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): ASCVD — YEARS

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY EMPHYSEMA

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 1, 1967 to May 6, 1967 that ( ) (we) last saw the deceased alive on May 6, 1967 and that death occurred at 3:35 P.M. from causes and on the date stated above

22a SIGNATURE: [signature] M.D. — ATTENDING PHYS ☐ — MED DIRECTOR ☐ — STAFF PHYS ☒
22b DATE SIGNED: May 6, 1967
22c PHYSICIAN'S NAME (Type): J. LEITH DAL
22d ADDRESS: 114 W. BEL AIR AVE. HAVRE DE GRACE, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: May 10, 1967
23c NAME OF CEMETERY OR CREMATORY: ASBURY CEM.
23d LOCATION (City or Town) (County) (State): CECIL Co. MD.

24 FUNERAL DIRECTOR: K. Wilson Mitchell — **ADDRESS**: Havre de Grace, Md.

25a REC'D BY REGISTRAR DATE: MAY 10 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06720 06706

1 PLACE OF DEATH
a COUNTY [illegible] MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
c LENGTH OF STAY IN 1b [illegible]
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pheasant Road

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE [illegible] b COUNTY [illegible]
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]
d STREET ADDRESS Prospect R
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print) First [illegible] Middle [illegible] Last [illegible]
4 DATE OF DEATH Month [illegible] Day [illegible] Year , 19

5 SEX [illegible]
6 COLOR OR RACE [illegible]
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH [illegible]
9 AGE (In years last birthday) yrs
IF UNDER 1 YEAR Months [illegible] Days [illegible]
IF UNDER 24 HRS Hours [illegible] Min [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b. KIND OF BUSINESS OR INDUSTRY [illegible]
11. BIRTHPLACE (County & State or foreign country) [illegible]
12 CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME [illegible]

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) [illegible]
16 SOCIAL SECURITY NO [illegible]
17 INFORMANT Address [illegible]

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Uremia
DUE TO
(b) Advanced Arteriosclerosis + Cerebral Thrombosis 6 mo
DUE TO and
(c) Right peripheral disease + non-functioning kidney 8 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH 3 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Hypertension - Moab. pneumonia (3 days)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from Sept , 19[illegible], to 22 May , 19[illegible], that (I) (we) last saw the deceased alive on 22 May , 19[illegible], and that death occurred at 4:22 M, from causes and on the date stated above.

22a SIGNATURE Edwin W. Whitfield Jr. M.D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED [illegible]
22c PHYSICIAN'S NAME (Type) [illegible]
22d ADDRESS [illegible]

23a BURIAL, CREMATION, REMOVAL (Specify) [illegible]
23b DATE THEREOF [illegible]
23c NAME OF CEMETERY OR CREMATORY [illegible]
23d LOCATION (City or Town) (County) (State) [illegible]

24 FUNERAL DIRECTOR John A Hawkins
ADDRESS [illegible]
25a RECD BY REGISTRAR DATE MAY 25 1967
25b REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and not later than 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06721

CERTIFICATE OF DEATH

06703

1 PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
c. LENGTH OF STAY IN 1b

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible] Street
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First T. Middle [illegible] Last Doyle
4 DATE OF DEATH Month [illegible] Day 20, Year 19 67

5 SEX Male
6 COLOR OR RACE White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH Nov. 8, 1888
9 AGE (In years last birthday) 78 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance
10b KIND OF BUSINESS OR INDUSTRY Public Schools
11 BIRTHPLACE (County & State, or foreign country) Harford Co., Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME Thomas J. Doyle
14 MOTHER'S MAIDEN NAME Mary M. Frederick

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No
16 SOCIAL SECURITY NO 219-36-0209
17 INFORMANT Address Thomas F. Doyle, Street, [illegible]

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 15 Min
DUE TO (b) Advanced arteriosclerotic cardiovascular disease — 6 yr.
DUE TO (c)
4211
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Exogenous obesity; osteoarthritis - knees - Spastic colon
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from April, 1960, to 29 May, 1967, that (I) ~~(we)~~ last saw the deceased alive on 22 May 1967, and that death occurred at 6:45 P.M., from causes and on the date stated above.

22a SIGNATURE Edward C. Whiteford Jr. M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED
22c PHYSICIAN'S NAME (Type) Edward C. Whiteford, Jr. M.D.
22d ADDRESS Whiteford, Md.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial
23b DATE THEREOF June 1, 1967
23c NAME OF CEMETERY OR CREMATORY Emory
23d LOCATION (City or Town) (County) (State) Street, Harford Co., Md.

24 FUNERAL DIRECTOR John H. Hopkins
ADDRESS Delt, [illegible]
25a RECD BY REGISTRAR DATE JUN 2 1967
25b REGISTRAR'S SIGNATURE [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36722 — 06709

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 126 So. Wash. ST
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: ANNA — Middle: LAURA — Last: ERWIN

4 DATE OF DEATH: Month: May — Day: 6 — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: April 27, 1897
9 AGE (In years last birthday): 70 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): House Wife
10b KIND OF BUSINESS OR INDUSTRY: Home
11 BIRTHPLACE (County & State or Foreign country): MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Francis Crawford
14 MOTHER'S MAIDEN NAME: Laura V. McEwing

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 217-07-1446
17 INFORMANT: Mrs. Virginia E. Holcomb — Address: Aberdeen, Md. R.R. #1 Box 54A.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — 2 weeks
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from April 27, 1967 to May 6, 1967 that (I) (we) last saw the deceased alive on May 6 1967, and that death occurred at 7 AM, from causes and on the date stated above.

22a SIGNATURE: Frank W. Wadsworth M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5/6/67
22c. PHYSICIAN'S NAME (Type)
22d ADDRESS

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 9 1967
23c NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens
23d LOCATION (City or Town) (County) (State): Harford Co. Md.

24. FUNERAL DIRECTOR: K. Madison Mitchell — ADDRESS: Havre de Grace, Md.
25a RECD. BY REGISTRAR DATE: MAY 10 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06723 06710

1 PLACE OF DEATH
a. COUNTY: Harford MARY.AND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): White Marsh
c. LENGTH OF STAY IN 1b: 3 days

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: Magnolia Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

3 NAME OF DECEASED (Type or print): First: Lorain Middle: M. Last: Faine

4 DATE OF DEATH: Month: 5 Day: 4 Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: May 29, 1909
9 AGE (In years last birthday): 57 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser
10b KIND OF BUSINESS OR INDUSTRY: Sewing Factory
11 BIRTHPLACE (County & State or foreign country): U.S.A.
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Jack Martin
14 MOTHER'S MAIDEN NAME: Ardmore Chrisman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 233-28-8342
17 INFORMANT Address: Mr. Troy Faine, Magnolia Rd., Joppa, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Left cerebral vascular accident
DUE TO (b): Calcinomatosis - left breast Cancer.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH: 2 hrs. / 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town) (County) State

21. I certify that (I) (this hospital) attended the deceased from Feb 1965 to May, 1967, that (I) (we) last saw the deceased alive on May 4 1967, and that death occurred at 6:55 P.M., from causes and on the date stated above.

22a SIGNATURE: W. H. Sadowsky M.D. ATTENDING PHYS ☒ MEDICAL DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 5/4/67
22c PHYSICIAN'S NAME (Type): W. H. SADOWSKY
22d ADDRESS: 504 Lewis St. Havre de Grace, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 8, 1967
23c NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens
23d LOCATION (City or Town) (County) (State): Aberdeen R.D. Harford Md

24 FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a RECD BY REGISTRAR DATE: MAY 8 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shguld be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06724 — 06711

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest): Havre de Grace
d. STREET ADDRESS: 614 Hope Terrace
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace — Middle: — Last: Farrell

4. DATE OF DEATH: Month: May — Day: 2 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/21/1895

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Cairns

14. MOTHER'S MAIDEN NAME: Grace McGregor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT: T.J. Farrell — Address: 614 Chapel Terrace, Havre de Grace, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic C V Disease — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ (3d Asst.)
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

Address (Street, city, town, or county):

DATE SIGNED: 5-3-67

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/6/67

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace, Md

23. FUNERAL DIRECTOR: Kenney Funeral Home, Havre de Grace Md — ADDRESS

24a. REC'D BY REGISTRAR DATE: MAY 8 1967

24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06725 — 06712

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville
c. LENGTH OF STAY IN MARYLAND: 2 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rockdale Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
e. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville RD #1 Box 627
d. STREET ADDRESS: Rockdale Ave.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Grant; Middle: Hazel; Last: Good

4. DATE OF DEATH: Month: May; Day: 2; Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 9/27/1906

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Gen. farming

11. BIRTHPLACE (County & State, or foreign country): Pocahontas Co. W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Kenny Newton Good

14. MOTHER'S MAIDEN NAME: Maudie Ann Morrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: ---

17. INFORMANT: 220-12-5814 Opal A. Good
Address: RD #1 Box 627
Churchville, Md. 21028

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.
DUE TO (b): Arteriosclerotic coronary artery disease — 15 yr.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.: Gastric carcinoma c obstruction of esophageal area

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Oct. 1957 to 2 May 1967, that (I) (we) last saw the deceased alive on 2 May 1967, and that death occurred at 6:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edwin W. Whiteford Jr. M.D

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 3 May 1967

22c. PHYSICIAN'S NAME (Type): Edwin W. Whiteford Jr.

22d. ADDRESS: Whiteford, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/5/1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Mem. Gardens

23d. LOCATION (City, town or county) (State): Bel Air Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Charles E. Kurtz Jarrettsville, Md. 21084

25a. RECD BY REGISTRAR DATE: MAY 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge.

1

FOR STATE HEALTH DEPT. [V]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06726 — 06713

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if ... delay, ... case except the certificate, writing the word pending in pencil in Item 18 G ... Pages 1 and 3 to the ... rector. Page 4 ... forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 ... be retained for your files

TO FUNERAL DIRECTOR: ... Item 3 ... as a burial-transit permit. File pages 1 and 2 with the State Department of Health ... to burial, cremation or removal and in any event within 72 hours after death

a. PLACE OF DEATH — COUNTY: Harford
ENTITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Fairview
LENGTH OF STAY IN ID:
c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived before death, not where died) — a. STATE: Md. — b. COUNTY: Harford
CITY OR TOWN (If outside corporate limits write RURAL): Aberdeen
d. STREET ADDRESS: 36 Hanover Street
RESIDENCE ON A FARM: yes ☐ N ☒

3. NAME OF DECEASED (Type or print): First: Roosevelt — Middle: Gregory — Last: Tr...
4. DATE OF DEATH: Month: May — Day: 11 — Year: 67
5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-27-47
9. AGE (Last birthday) yrs: 19
UNDER 1 YEAR — Months: — Days: — HOURS: — MINUTES:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Lumber Co.,
11. BIRTHPLACE (State or Foreign Country): Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Roosevelt A. Gregory Sr.
14. MOTHER'S MAIDEN NAME: Mary ... Mayo
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO: 224-56-6211
17. INFORMANT: Wife, Same as 2 a & b. Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ruptured liver
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
ENTER A REMARKABLE INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
AUTOPSY PERFORMED? YES ☐ NO ☒

19. INJURY: EXTERNAL CAUSE — PRIMARY ☒ or CONTRIBUTING ☐ (Accident, Suicide, Homicide)
20a. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, Part II or Item 18): Ford ... turned over on him
20b. TIME OF INJURY (Month, Day, Year, Hour): 4:30 — 5-11-67
20c. INJURY OCCURRED: While at work ☒ Not While at work ☐
20d. PLACE OF INJURY (Home, factory, street, office bldg., etc.): Aberdeen Motors
20e. (City, town or county): Aberdeen

21. I certify that I took charge of the remains described above and on Autopsy [ ] Inspection [☒] and that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined ☐
ACTUAL SIGNATURE OF MD: Gerald C. Palmer, M.D.
EXAMINER'S NAME: Gerald C. Palmer, M.D.
CHIEF MEDICAL EXAMINER ☐ BOARD ☐
ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: 5-14-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 14 May 67
23c. NAME OF CEMETERY OR CREMATORY: South Hill Cemetery
23d. LOCATION (City or Town) (County) (State): South Hill, Virginia
NAME OF FUNERAL DIRECTOR OR AGENT: Tarring Funeral Home
ADDRESS OF FUNERAL DIRECTOR: Aberdeen, Md.
Webster Macomber Sr.
DATE: MAY 15 1967
Coroner, Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36727 — 06714

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: PO Box 62
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James — Middle: Harry — Last: Hanna — Sr.

4 DATE OF DEATH: Month: May — Day: 16 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Aug. 11, 1885
9 AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b KIND OF BUSINESS OR INDUSTRY: auto accessories
11 BIRTHPLACE (County & State or foreign country): W. Va.
12 CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Calvin H. Hanna
14 MOTHER'S MAIDEN NAME: Mary Kincaid

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO.: 234-20-7219
17 INFORMANT: Address: Mrs. Vera G. Hanna, Box 62, Bel Air, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Vascular thrombosis + A.S.C.V.D.

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 11 1967, to May 16, 1967, that (I) (we) last saw the deceased alive on May 16 1967, and that death occurred at 7:45 A.M., from causes and on the date stated above.

22a. SIGNATURE: Edward C. Lee, M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/16/67
22c. PHYSICIAN'S NAME (Type): Edward C. Lee, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air, Harford, Md

24. FUNERAL DIRECTOR: Howard K. McComas & Son, Abingdon, Md.
25a. FILED BY REGISTRAR: DATE: MAY 18 1967
25b. REGISTRAR'S SIGNATURE: Orphans Court Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06723 — 06715

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood Arsenal
d. STREET ADDRESS: 6508 Hawthorne Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Everette — Middle: Eugene — Last: Hicks

4. DATE OF DEATH: Month: May — Day: 8 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 27 June 35

9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (County & State, or foreign country): Prescott, Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Hicks

14. MOTHER'S MAIDEN NAME: Laura Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): Feb 55 - May 67

16. SOCIAL SECURITY NO.: 578-48-8582

17. INFORMANT: Personnel Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarct(?)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocarditis(?)
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 8 May, 1967, to 8 May, 1967, that I (we) last saw the deceased alive on 8 May 1967, and that death occurred at 5:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Thomas Fraher MD — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 8 May 1967

22c. PHYSICIAN'S NAME (Type): THOMAS FRAHER, M.D.

22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: May 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah Cemetery

23d. LOCATION (City, town or county) (State): Prescott, Arkansas

24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 12 1967

25b. REGISTRAR'S SIGNATURE: Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05723

CERTIFICATE OF DEATH

D5716

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Md. — b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre de Grace

c. LENGTH OF STAY IN 1b: 3 days

c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Aberdeen

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

d. STREET ADDRESS: [illegible] Rt Box 42

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Grover — Last: Hiob Sr.

4. DATE OF DEATH: Month: May — Day: 1 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 April 1885

9. AGE (In years last birthday): 82 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electro Type & Farmer)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Md. (Balto.)

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Charles Casper Hiob (D)

14. MOTHER'S MAIDEN NAME: Catherine Kampe (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 213-05-8769-A)

17. INFORMANT: Wife, Same as 2 C & D. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))

PART I. DEATH WAS CAUSED BY

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia Acute	4 days
DUE TO (b)	Congestive Heart failure	1 yr
DUE TO (c)	Generalized Arteriosclerosis	5 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from January 1, 1960 to May 1, 1967 that (I) (we) last saw the deceased alive on May 1 1967, and that death occurred at 7:45 p.m., from causes and on the date stated above

22a. SIGNATURE: Dudley Phillips MD — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 5/1/67

22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD

22e. ADDRESS: Darlington MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/4/67

23c. NAME OF CEMETERY OR CREMATORY: St Paul Lutheran Cemetery)

23d. LOCATION (City or Town) (County) (State): Aberdeen, Md.

24a. FUNERAL DIRECTOR: Webster Macomber Sr. — ADDRESS: Harring Funeral Home Aberdeen, Md.

25a. RECD BY REGISTRAR: DATE MAY 4 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06730

CERTIFICATE OF DEATH

06717

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: 38 Granite Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: F — Last: Holland
4. DATE OF DEATH: Month: 5 — Day: 13 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 25, 1907
9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Engineer
10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt. Baltimore
11 BIRTHPLACE (County & State or foreign country): South Carolina
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John F. Holland, Sr.
14. MOTHER'S MAIDEN NAME: Minnie L. Smith

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 557-32-1505
17 INFORMANT: Cecil E. Holland, 8364 Jefferson St., N.E. Address: Washington, D.C.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: a few min.
DUE TO (b): Arteriosclerosis
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from Feb. 7, 19 67 to May 8, 19 67 that (I) (we) last saw the deceased alive on May 13 19 67, and that death occurred at 2:40 P.M., from causes and on the date stated above

22a SIGNATURE: Clarence I. Benson — M.D. — ATTENDING PHYS ☒ MEDICAL DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: May 17, 1967
22c PHYSICIAN'S NAME (Type): Clarence I. Benson, M.D.
22d ADDRESS: Port Deposit, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 18, 1967
23c NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Cemetery
23d LOCATION (City or Town) (County) (State): Washington, D. C.

24 FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Maryland
25a REC'D BY REGISTRAR DATE: MAY 19 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06731

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06718

1. PLACE OF DEATH a. COUNTY: Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): DOA ... Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 47 Bush Chapel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Douglas Middle: Last: Hundley
4. DATE OF DEATH Month: May Day: 5 Year: 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 25, 1917
9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR Months / Days IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Odd Jobs
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: No record
14. MOTHER'S MAIDEN NAME: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 224-52 7180
17. INFORMANT: Mrs. Mary Eliza Hundley, wife Address: ... Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald C Palmer, M.D.
Address (Street, city, town, or county): Bel Air, Md.
22. DATE SIGNED: 5-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 7, 1967
23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cem.
23d. LOCATION (City, town or county) (State): ... Md.

24. FUNERAL DIRECTOR: ... ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: MAY 8 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR AISME (5)
5M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36732

CERTIFICATE OF DEATH

06719

1 PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
c. LENGTH OF STAY IN 1b: 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): none

2 USUAL RESIDENCE (Where deceased lived if institution Residence Before Admission)
a. STATE Maryland — b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
d. STREET ADDRESS: 2921 Willoughby Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ARTHUR — Middle AUGUST — Last KERSHAW

4 DATE OF DEATH: Month May — Day 11 — Year 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Nov. 1, 1890
9 AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b KIND OF BUSINESS OR INDUSTRY: U.S. Govt - Ret.
11 BIRTHPLACE (County & State or foreign country): Detroit, Michigan
12 CITIZEN OF WHAT COUNTRY: USA

13 FATHER'S NAME: Theodore Kershaw
14 MOTHER'S MAIDEN NAME: Mary Boelter

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16 SOCIAL SECURITY NO: 220-20-7979
17 INFORMANT: Mrs. Edna Viola Kershaw, Address Edgewood, Md. 2921 Willoughby Beach Road

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): ACUTE CONGESTIVE FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 30 MIN
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): HYPERTENSIVE ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE — OVER 12 YRS
DUE TO
(c):

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from MAY 13, 19 54 to MAY 11, 1967 that (I) (we) last saw the deceased alive on MAY 11 1967, and that death occurred at 7:55 A.M., from causes and on the date stated above.

22a SIGNATURE: Philip J. Heuman — M.D. ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Philip J. Heuman, M.D.
22e. ADDRESS 307 Hickory Avenue, Bel Air, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cemetery
23d. LOCATION (City or Town) (County) (State): Baltimore Md

24 FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a RECD BY REGISTRAR DATE: MAY 15 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06733 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 06760

PLACE OF DEATH: COUNTY Harford; CITY OR TOWN (If outside city limits, write RURAL and give name of town) Fallston; MARYLAND LENGTH OF STAY IN

NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

USUAL RESIDENCE: STATE Md; CITY OR TOWN Fallston; COUNTY Harford

STREET ADDRESS

RESIDENCE ON A FARM YES X NO

NAME OF DECEASED: First Winston; Middle Thomas; Last Kourey

DATE OF DEATH: Month May; Day 3; Year 67

SEX: M

COLOR OR RACE: W

MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

DATE OF BIRTH: 5/30/1927

AGE (Last birthday) 39 yrs

IF UNDER 1 YEAR: Months; Days; UNDER 1 DAY: Hrs.; Min.

10a OCCUPATION (Give kind of work done during most of working life, even if retired): BALTO. TRANSIT CO.

10b KIND OF BUSINESS OR INDUSTRY: TRANSPORTATION

11 BIRTHPLACE (State or foreign country): Md

12 IF OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: SALEM W. KOUREY

14 MOTHER'S MAIDEN NAME: HELEN MEYER

WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service): Yes WW II

16 SOCIAL SECURITY NO: 219-22-8165

17 INFORMANT: DR. SALEM W KOURY (SAME)

18 CAUSE OF DEATH (Enter only one cause per line for a, b and c.)

PART I DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)): Multiple Sclerosis

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

AUTOPSY? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above; I last saw the deceased alive on [illegible]; death resulted from Natural cause ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined ☐

CHIEF MEDICAL EXAMINER ☐ Dr. A. [illegible]

ACTUAL SIGNATURE: Gerald C Palmer

EXAMINER'S NAME: Gerald C Palmer (M.D.)

DEPUTY MEDICAL EXAMINER ☒

22 DATE SIGNED: 5-3-67

REMOVAL (Specify) Burial; 5/6/1967; Loudon Park; Baltimore, Md.

H. W. Jenkins & Sons Co. 4905 York Rd. Balto.12, Md.

MAY 5 1967

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if [illegible] the certificate writing the word pending in pencil in Item 18 Give Page 1 2 and [illegible] 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit Five pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME 6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06734 — 06721

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa,
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): none

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: 1407 Old Joppa Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: May — Last: Limbert

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months — IF UNDER 24 HRS.: Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress Maker

10b. KIND OF BUSINESS OR INDUSTRY: Mfg.

11. BIRTHPLACE (County & State, or foreign country): Tower City, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Shomper

14. MOTHER'S MAIDEN NAME: Tammie Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 162-07-8362

17. INFORMANT: Irvin Limbert, 1407 Old Joppa Rd., Joppa, Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro vascular occlusion Cardiac failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Parkinson's

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan., 1967, to May, 1967, that (I) (we) last saw the deceased alive on May 9, 1967, and that death occurred at 1035 A.M., from the causes and on the date stated above.

22a. SIGNATURE: William A. Tyson M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-9-67

22c. PHYSICIAN'S NAME (Type): William A Tyson

22d. ADDRESS: Kingsville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: May 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Buffington Funeral Home

23d. LOCATION (City, town or county) (State): Valley View, Pa.

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009

25a. REC'D BY REGISTRAR DATE: MAY 11 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06735 — 06722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M S-63

1. PLACE OF DEATH
a. COUNTY: Harford — Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 16: 35 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 701 S. Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Edna — Middle: Winkler — Last: Maloney

4. DATE OF DEATH: Month: 5/14 — Day — Year: 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☑

8. DATE OF BIRTH: 5/25/1893

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Wilmington Del. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas R. Winkler

14. MOTHER'S MAIDEN NAME: Dora J. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Mrs Lucy McMaster — Address: 860 S Washington St Havre de Grace Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastrointestinal Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Malignancy of G.I. tract — 2-3 Mo
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: A.S.V.D. and Nutritional anemia + Dyspepsia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day — Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 14th 1967 to 5/13th 1967 that (I) (we) last saw the deceased alive on 5/13th 1967 and that death occurred at 10:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Wood M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/15/67

22c. PHYSICIAN'S NAME (Type): Edward C. Wood

22d. ADDRESS: Harford Memorial Hosp.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/17/67

23c. NAME OF CEMETERY OR CREMATORY: Riverview

23d. LOCATION (City, town or county) (State): Wilmington Del.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Pennington Bros. Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE: MAY 17 1967

25b. REGISTRAR'S SIGNATURE: Florence Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36736

CERTIFICATE OF DEATH

06723

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: N/A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE: New Jersey — b. COUNTY: Burlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willingboro
d. STREET ADDRESS: 16 Gamewell Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: James — Middle: D. — Last: MATTHEWS

4 DATE OF DEATH: Month: May — Day: 15, — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: September 2,1947

9 AGE (In years last birthday): 19 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b KIND OF BUSINESS OR INDUSTRY: US Army

11 BIRTHPLACE (County & State or foreign country): Philadelphia, Pa.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James J. Matthews

14. MOTHER'S MAIDEN NAME: Dorothy Anderson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 12 October 66 - 15 May 67

16 SOCIAL SECURITY NO: 230-66-8322

17 INFORMANT — Address: DA 41 Personnel Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fractured skull
DUE TO
(b)
DUE TO
(c) Automobile Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Immediate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER NOT BY MED. CA. EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Deceased was a passenger in an auto involved in an accident.

20c TIME OF INJURY (Hour, am/pm, Month, Day, Year): 1:00 pm May 15, 19 67

20d INJURY OCCURRED: While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): JFK Hwy Rte 95

20f (City or town, County, State): Whitemarsh, Baltimore, Md.

21 I certify that ☒ (this hospital) attended the deceased from 15 May , 19 67 to 15 May , 19 67 that ☒ (we) last saw the deceased ~~alive~~ on DOA 15 May 1967, and that death occurred at 2:00 AM, from causes and on the date stated above

22a SIGNATURE: Thomas Fraher MD — MD ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 15 May 1967

22c. PHYSICIAN'S NAME (Type): THOMAS FRAHER, M.D.

22d ADDRESS: Kirk Army Hospital, APG, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 17 May 67

23c NAME OF CEMETERY OR CREMATORY: St Marys Cemetery

23d LOCATION (City or Town) (County) (State): Mt Holly, New Jersey

FUNERAL DIRECTOR: Welsh Macomber Sr.

ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a RECD BY REGISTRAR — DATE: MAY 18 1967

25b REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06737

CERTIFICATE OF DEATH

06724

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 7 hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Rt 3 Box 311
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle L. — Last MILLER

4. DATE OF DEATH: Month MAY — Day 7 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 19 February 1918

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress-Cook
Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Restaurants

11. BIRTHPLACE (County & State, or foreign country): Harford Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Mathews

14. MOTHER'S MAIDEN NAME: Lillian Wolfington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-01-9734

17. INFORMANT: CLAUDE MILLER, Rt 3 Box 311, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 May, 19 67, to 7 May, 1967, that (I) (we) last saw the deceased alive on 7 May 19 67, and that death occurred at 6:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: Thomas Fraher MD — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 7 May 67

22c. PHYSICIAN'S NAME (Type): THOMAS FRAHER, MD

22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial

23b. DATE THEREOF: 10 May 67

23c. NAME OF CEMETERY OR CREMATORY: Grove Cemetery

23d. LOCATION (City, town or county) (State): Aberdeen, Maryland

24. FUNERAL DIRECTOR: Harry Warring — ADDRESS: Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 10 1967

25b. REGISTRAR'S SIGNATURE: Marie Judge

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06736 06725

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-ABERDEEN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MD
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: WILLIAM Middle: OTHO Last: MILLER

4. DATE OF DEATH: Month: MAY Day: 18 Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: DEC 16, 1885

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JAMES

14. MOTHER'S MAIDEN NAME: MARY HARE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion
DUE TO (b): Arteriosclerotic (12 wks)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mr. Arteriosclerotic Psychosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 19 22 to May 11 19 67, that (I) (we) last saw the deceased alive on May 11 19 67, and that death occurred at 7A M, from the causes and on the date stated above.

22a. SIGNATURE: Ralph Hoke

22b. DATE SIGNED: 5/19/67

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] M.D.

22c. PHYSICIAN'S NAME (Type): Ralph Hoke

22d. ADDRESS: Churchville

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Wesleyan Chapel Cem.

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

25a. REC'D BY REGISTRAR DATE: MAY 22 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1S (4)
20M 5 63

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06733 O

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood Arsenal, Md.
c. LENGTH OF STAY IN 1b: approx. 6 hrs. on 28 May 67
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USA Dispensary, Edgewood Arsenal

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Maryland 21215
d. STREET ADDRESS: 2817 Ruscombe Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: Joseph — Last: Milloff

4. DATE OF DEATH: Month: May — Day: 28 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1945

9. AGE (In years last birthday): 22 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemical Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Fed. Civ. Svc.

11. BIRTHPLACE (County & State, or foreign country): Baltimore Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Milloff

14. MOTHER'S MAIDEN NAME: Florence Fischer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: 214-44-6561

17. INFORMANT: (Uncle) Robert Fischer, Baltimore, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heat stroke

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Thermal control failure
DUE TO (c): Environmental heat

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 24 August, 19 66, to 28 May, 19 67, that (I) (we) last saw the deceased alive on 28 May 1967, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Ernest N. Moss — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 27 June 1967

22c. PHYSICIAN'S NAME (Type): ERNEST N. MOSS, LTC, MC

22d. ADDRESS: USA Dispensary, Edgewood Arsenal

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 29 May 1967

23c. NAME OF CEMETERY OR CREMATORY: Tifereth Israel Anshe Sfard Cemetary

23d. LOCATION (City, town or county) (State): Rosedale (Balto. Co.) Md.

24. FUNERAL DIRECTOR: Sol Levinson & Bros. — ADDRESS: 6010 Reisterstown Rd. Baltimore, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 30 1967

25b. REGISTRAR'S SIGNATURE

VR A15 (4)
2DM 1/65

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word pending in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06740 — 06727

Field	Entry
1. PLACE OF DEATH a. COUNTY	Harford — MARYLAND
b. CITY OR TOWN (If outside limits, write RURAL and give nearest town)	Havre de Grace
c. LENGTH OF STAY IN 1b	DOA
d. NAME OF HOSPITAL OR INSTITUTION	DOA Harford Memorial Hospital
2. USUAL RESIDENCE a. STATE	Md
b. COUNTY	Cecil
c. CITY OR TOWN	Perryville
d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM	No X
3. NAME OF DECEASED (Type or print) First / Middle / Last	Thelma A. Moore — Thelma Moore
4. DATE OF DEATH Month / Day / Year	May 1 1967
5. SEX	F
6. COLOR OR RACE	W
7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	Married [X]
8. DATE OF BIRTH	Aug. 9, 1913
9. AGE (last birthday)	53 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Housewife
10b. KIND OF BUSINESS OR INDUSTRY	------------
11. BIRTHPLACE (State or foreign country)	Virginia
12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME	William P. Hawley
14. MOTHER'S MAIDEN NAME	Mattie Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	No ------
16. SOCIAL SECURITY NO.	220-44-0542
17. INFORMANT / Address	Edward E. Moore, Perryville, Md. 21903

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
19. AUTOPSY? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. LOCATION

21. I certify that I took charge of the body described above and that (Autopsy [ ] [X] [X]) in my opinion death resulted from Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined [ ]

ACTUAL SIGNATURE: Gerald E. Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer MD
CHIEF MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Bel Air, Md
22. DATE SIGNED: 5-1-67

BURIAL, CREMATION, REMOVAL	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION
Burial	5/4/1967	Asbury Cemetery	Port Deposit, Md. Cecil

FUNERAL DIRECTOR: Lee A. Patterson & Son, Perryville, Md.
DATE REC'D BY REGISTRAR: 1967 — [signature]

VR A EME 5M 6

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06741 — 06728

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Havre de Grace
c. LENGTH OF STAY IN 1b: 95 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. # 2 Box 21078

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Havre de Grace 21078
d. STREET ADDRESS: R.D. # 2 Box
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: George — Middle: L. — Last: Ostorn
4. DATE OF DEATH: Month: May — Day: 27 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 20 1871
9. AGE (In years last birthday): 95 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George V. Ostorn
14. MOTHER'S MAIDEN NAME: Martha Margaret Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 220-30-3880
17. INFORMANT: Mrs. Corinna S. Himes — Address: 11 Franger ST. Havre de Grace Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Insufficiency
DUE TO (b): Myocarditis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Age
INTERVAL BETWEEN ONSET AND DEATH:

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1946, 19..., to 5-27-67, 19..., that (I) (we) last saw the deceased alive on 5-26-67, 19..., and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): [signature] M.D.
22d. ADDRESS: Havre de Grace Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 29 1967
23c. NAME OF CEMETERY OR CREMATORY: Wilson Chapel Cem.
23d. LOCATION (City, town or county): Harford Co. (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Madison Mitchell, Havre de Grace Md.
25a. REC'D BY REGISTRAR DATE: MAY 31 1967
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4) 2DM S-63

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06742

CERTIFICATE OF DEATH

06723

I

1 PLACE OF DEATH
a COUNTY Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE Md. b COUNTY Harford

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Grds

c LENGTH OF STAY IN 1b

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Grounds

d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital

d STREET ADDRESS 2728 c West Court ST.

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First: Janet Middle: M Last: PAPES

4 DATE OF DEATH Month: May Day: 13 Year: 1967

SEX: Female

6 COLOR OR RACE: CAU

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 11 Aug 64

9 AGE (If under 1 year or 1 day) last birthday) 2 yrs.

IF UNDER 1 YEAR: Months 9 Days

IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A Infant

10b KIND OF BUSINESS OR INDUSTRY N/A

11 BIRTHPLACE (County & State or foreign country) Harford Co, Md

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME William A. PAPes

14 MOTHER'S MAIDEN NAME Margaret Fisher

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16 SOCIAL SECURITY NO None

17 INFORMANT Address: Mother, Same as 2 C · ·

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Neuroblastoma, metastatic — INTERVAL BETWEEN ONSET AND DEATH 8 mos.

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from 13 May, 1967, to 13 May, 1967, that (I) (we) last saw the deceased alive on 13 May 1967, and that death occurred at 11:50 PM, from causes and on the date stated above.

22a SIGNATURE Leland W. Wight Jr. M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b DATE SIGNED 13 May 67

22c PHYSICIAN'S NAME (Type) Leland W. Wight Jr. M.D.

22d ADDRESS Aberdeen Proving Ground, Md.

23a BURIAL, CREMATION, REMOVAL (Specify) Burial

23b DATE THEREOF 5/16/1967

23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Ft. Myer,

23d LOCATION (City or Town) (County) (State) Va.

24 FUNERAL DIRECTOR Walter Macomber Sr.

ADDRESS Parrin Funeral Home Aberdeen, Md.

25a RECD BY REGISTRAR DATE MAY 16 1967

25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06743 — 06730

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2hrs 30 min

2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Magnolia

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital
d. STREET ADDRESS: 512 Dembytown Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Willie — Middle: — Last: Porcher
4. DATE OF DEATH: Month: May — Day: 4 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 1914
9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (County & State, or foreign country): Georgetown, S.C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Willie Porcher, Sr.
14. MOTHER'S MAIDEN NAME: Janie Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII
16. SOCIAL SECURITY NO: 249-07-5170
17. INFORMANT: Mrs. Mary Peters Porcher, Address: Joppa, Md. 51? Dembytown Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instantaneous
DUE TO (b): Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Arteriosclerotic Cardiovascular Disease — 3-4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a.: Old Posterior Coronary Thrombosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 26, 1966 to May 4 1967 that (I) (we) last saw the deceased alive on May 4 1967, and that death occurred at 11:45 P.M., from causes and on the date stated above

22a. SIGNATURE: Edward C. Loc, M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5/4/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loc, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 8, 1967
23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Baptist Cemetery
23d. LOCATION (City or town) (County) (State): Magnolia Harford Md

24. FUNERAL DIRECTOR: Howard K. McComas & Son, ADDRESS: Abingdon, Md. 21009
25a. RECEIVED BY REGISTRAR DATE: MAY 8 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06744 — 06731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
c. LENGTH OF STAY IN Md: 5 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Fallston Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
d. STREET ADDRESS: (P.O.Box#63) Old Fallston Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Heidi; Middle: ~~Quesenberry~~; Last: Quesinberry
4. DATE OF DEATH: Month: May; Day: 25,; Year: 1967
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 13, 1962
9. AGE (In years last birthday): 4 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Maricopa,Co., Arizona
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: ~~Quesenbery~~ Lonnie Ray Quesinberry, Jr.
14. MOTHER'S MAIDEN NAME: Ruth Ann Pierce
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): No
16. SOCIAL SECURITY NO.: none
17. INFORMANT (Father) 838-9245 P.O. Box #63 21047: Mr. L. Ray Quesinberry, Jr. Fallston, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Haemorrhage, Medulla
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 19 67 to 5/25/ 19 67, that (I) (we) last saw the deceased alive on 5/25/ 19 67, and that death occurred at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Kermit D. Bonovich M.D.
22b. DATE SIGNED: May 25, 1967
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): Kermit Bonovich M.D.
22d. ADDRESS 879-0717 Fallston, Maryland 21047

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 27,1967
23c. NAME OF CEMETERY OR CREMATORY: Mountain Christian Ch. Cem.
23d. LOCATION (City, town or county) (State): Joppa, Harf. Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph William Foster ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a. REC'D BY REG.STRAR DATE: MAY
25b. REGISTRAR'S SIGNATURE: Judge

Joseph William Foster

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 (M) 06745

CERTIFICATE OF DEATH

06732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pylesville
c. LENGTH OF STAY IN 1b: 3 Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Penna. — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fawn Grove
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Violet — Middle: Viatrice — Last: Roberts
4. DATE OF DEATH: Month: May — Day: 1, — Year: 19 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/12/1910
9. AGE (In years last birthday): 56 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Luther Perkins
14. MOTHER'S MAIDEN NAME: Pearl Cochran
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 234-54-2975
17. INFORMANT: Address: Mrs. Marie Measley, Pylesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to May 1, 1967, that (I) (we) last saw the deceased alive on May 1 19 67, and that death occurred at 5:20 P.M., from causes and on the date stated above

22a. SIGNATURE: Josiah A Hunt M.D — ATTENDING PHYS ☒ MEDICAL DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5/2/67
22c. PHYSICIAN'S NAME (Type): Josiah A Hunt MD
22d. ADDRESS: Delta, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/4/67
23c. NAME OF CEMETERY OR CREMATORY: Norrisville
23d. LOCATION (City or Town) (County) (State): Norrisville, Harford Co. Md.

24. FUNERAL DIRECTOR: Kenneth R. Osborne
ADDRESS: Stewartstown, Pa.
25a. REC'D BY REG STRAR DATE: MAY 4 1967
25b. REGISTRAR'S SIGNATURE: Helen Judge

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06733

1 PLACE OF DEATH
a COUNTY: Harford
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bel Air
LENGTH OF STAY IN: 3 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland
b COUNTY: Harford
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bel Air
d STREET ADDRESS (Wheel Road): Route 3, Box 335
e INSIDE CITY LIMITS? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First CHARLES Middle Frederick Last SANDERS
4 DATE OF DEATH: Month May Day 29 Year 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: Nov. 9, 1948
9 AGE (Last birthday): 18 yrs
UNDER 1 YEAR: Months / Days
1 TO 24 YRS: Hrs. / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TREE TRIMMER
10b KIND OF BUSINESS OR INDUSTRY: Asplundh Tree Expt. Co.
11 BIRTHPLACE (State or foreign country): Baltimore City, Maryland
12 CITIZEN OF WHAT COUNTRY: U.S.A.

13 FATHER'S NAME: William Dennis Sanders
14 MOTHER'S MAIDEN NAME: Grace Taylor
WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 218-50-6177
17 INFORMANT (Mother) 838-9238 Add.: R.D.#3, Box #335 Bel Air, Md. 21014

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Salicylate Overdose
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
AUTOPSY? YES [ ] NO [ ]

MED. EXAMINER'S CERTIFICATE

20a EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Ingested overdose of aspirin
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Yea. 5/27 19 67
20d INJURY OCCURRED While at work [ ] Not While at work [X]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f (City, town, or county): Bel Air (Harford) Maryland

21 I certify that I took charge of the remains described above and on Autopsy [ ] Inspect [X] Inquiry [ ] on my opinion death resulted from Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
Address (Street, city, town, or county)
22. DATE SIGNED: 5/29/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 31, 1967
23c NAME OF CEMETERY OR CREMATORY: Mt. Carmel Meth. Ch. Cem.
Emmorton, Harford Co., Maryland

24 FUNERAL DIRECTOR: Joseph William Foster
ADDRESS: W Broadway & Williams St. Bel Air, Maryland 21014
25c RECEIVED BY REGISTRAR DATE: JUN 1 1967
25d REGISTRAR NATURE: [signature]

Joseph William Foster

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary please execute the certificate writing the word pending in pencil in Item 18 Give Pages 1 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be given to burial transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
6M 67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

36747 — 06734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. **PLACE OF DEATH**
a. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harve de Grace
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harve de Grace
d. STREET ADDRESS: 1113 Hamilton Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Marie; Middle: R.; Last: Schutz
4. **DATE OF DEATH**: Month: 5; Day: 25; Year: 196[illegible]
5. SEX: [illegible]e
6. COLOR OR RACE: [illegible]ite
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 5-12-1[illegible]03
9. AGE (In years last birthday): 3 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ousewife
10b. KIND OF BUSINESS OR INDUSTRY: ousewife
11. BIRTHPLACE (County & State or foreign country): altimore, arylan[illegible]
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: John R. Hecker
14. MOTHER'S MAIDEN NAME: Mary J. Murphy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr Norval Schutz
Address: 1113 Hamilton Avenue #6

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: One Year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December ... 19[illegible] to 5-25-1967, that (I) (we) last saw the deceased alive on 5-23-1967, and that death occurred at 5:05 P.M. from the causes and on the date stated above

22a. SIGNATURE: [illegible]
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-26-67
22c. PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.
22d. ADDRESS: 8 Law St., P.O. Box 548, Aberdeen, Md. 2[illegible]

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-27-1967
23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d. LOCATION (City, town or county): Baltimore (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible]

25a. RECD BY REG. STRAR DATE: MAY 31 1967
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT. [VI]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

96743 06735

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

[I]

1a PLACE OF DEATH (If not in hospital give street address or location) Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Havre de Grace
c LENGTH OF STAY IN THIS PLACE 8 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Susquehanna River

2 USUAL RESIDENCE (Where deceased lived) a STATE Md. b COUNTY Harford (Cecil)
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Perry Point
STREET ADDRESS Box 456
RESIDENCE ON A FARM YES [ ] NO [X]

3 NAME OF DECEASED (Type or print) First: Junior Middle: K. Last: Simmons
4 DATE OF DEATH Month: May Day: 22 Year: 1967

5 SEX: M
6 COLOR OR RACE: W
7 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: 1-13-24
9 AGE (In years last birthday): 43 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HOURS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GUARD
10b KIND OF BUSINESS OR INDUSTRY: VA HOSP PERRY POINT
11 BIRTHPLACE (State or foreign country): MARSHAL Co W Va
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Z. L. Simmons
14 MOTHER'S MAIDEN NAME: BERTIE L MASON Moundsville W Va

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II
16 SOCIAL SECURITY NO: UNK
17 INFORMANT: Mr David Logsdon 108 Washington Ave Moundsville W Va

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for a, b, and c.)
PART I DEATH WAS CAUSED BY:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(a) IMMEDIATE CAUSE: Asphyxia Due to Drowning
DUE TO
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
975X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
AUTOPSY PERFORMED YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury. Do not use Part I or Part II terms.): Jumped off JFK Bridge
20c TIME OF INJURY Month, Day, Year: 5-10-5-14-67
20d INJURY OCCURRED WHILE at work [ ] Not while at work [X]
20e PLACE OF INJURY (Specify home, farm, factory, street, office building, etc.): JFK Bridge
20f Havre de Grace Md.

21 I certify that I took charge of the remains of the above named decedent on the date and hours stated above, held an Autopsy [ ], Inquest [X], and that in my opinion death resulted from Natural causes [ ] Suicide [X] Homicide [ ]

ACTUAL SIGNATURE OF MEDICAL EXAMINER: Gerald E Palmer
EXAMINER'S NAME (Type): Gerald E Palmer
ADDRESS OF MEDICAL EXAMINER: Belair Md
DEPUTY MEDICAL EXAMINER [X]
22 DATE SIGNED: 5-22-67

DISPOSITION: REMOVAL 5/23/1967
NAME OF CEMETERY OR CREMATORY: LIMESTONE CEMETERY
LOCATION (City or Town, State): MOUNDSVILLE MARSHAL Co W VA
FUNERAL DIRECTOR AND ADDRESS: Pennington & Son Havre de Grace Md
DATE: MAY 29 1967
REGISTRAR: Charles Judge

VR ATSME CM 6

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

96748

CERTIFICATE OF DEATH

06736

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Bruvin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: Apt. # 33, 126 Hickory Avenue
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Albert — Last: Simon

4. DATE OF DEATH: Month: May — Day: 1 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Jan. 22, 1882

9. AGE (In years last birthday): 85 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Simon

14. MOTHER'S MAIDEN NAME: Elizabeth (illegible) Bauer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO: 716-01-4931

17. INFORMANT (with) 9 8-36 5 — Address: 126 Hickory Ave Apt 33, Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO
(b): Pyelonephritis — 15 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): —

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): old age

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 1, 19 67 to 4-30 1967, that (I) (we) last saw the deceased alive on 4-30 1967, and that death occurred at 7:30 A.M., from causes and on the date stated above.

22a. SIGNATURE: John D. Yin M.D. — ATTENDING PHYS ☒ — MED. DIRECTOR ☐ — STAFF PHYS ☐

22b. DATE SIGNED: May 1, 1967

22c. PHYSICIAN'S NAME (Type): John D. Yin M.D.

22d. ADDRESS: 615 S. Union Ave, Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: Rock Spring Episcopal Ch. Cem.

23d. LOCATION (City or Town) (County) (State): Forest Hill, Harford Co., Md.

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. RECD BY REGISTRAR — DATE: MAY 2 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 of 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

26750 — 06737

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 a. PLACE OF DEATH — COUNTY: HARFord — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 57 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md — b. COUNTY: HARford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First HARRY — Middle A — Last Smith

4 DATE OF DEATH: Month MAY — Day 13 — Year 19 67

5 SEX: Male
6 COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Nov. 29, 1903
9 AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cable Splicer
10b KIND OF BUSINESS OR INDUSTRY: US Govt - Ret.
11 BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Harry Gregory Smith
14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 1928-1940
16 SOCIAL SECURITY NO: 214-26-8923
17 INFORMANT: Mrs. Katherine I. Smith, [illegible] Address: Abingdon, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerotic CV Disease — 8 yrs
DUE TO (c): Diabetes Mellitus — 20 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19 [illegible] to May 13 19 67 that (I) (we) last saw the deceased alive on May 13 19 67 and that death occurred at 8:05 A.M. from causes and on the date stated above

22a SIGNATURE: H Ralph Hinky MD — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5/13/67
22c PHYSICIAN'S NAME (Type): H Ralph Hinky MD
22d ADDRESS: Churchville Hwy. Md

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 15, 1967
23c NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d LOCATION (City or Town) (County) (State): Bel Air Harford Md

24 FUNERAL DIRECTOR: Howard W. Thomas & Son, Abingdon, Md. 21009
ADDRESS
25a RECD BY REGISTRAR DATE: APR 15 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36751 — 06738

1 PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 107 Holloway Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle A. — Last STAPLES

4. DATE OF DEATH: Month May — Day 23 — Year 19 67

5 SEX: Male

6 COLOR OR RACE: Caucasian

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: 14 Nov. 1888

9 AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Railroad Engineer

10b KIND OF BUSINESS OR INDUSTRY: Railroad (Ret.)

11 BIRTHPLACE (County & State or foreign country): Pennsylvania

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Reuben Staples (D)

14 MOTHER'S MAIDEN NAME: Elizabeth Thomas (D)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16 SOCIAL SECURITY NO: 705-12-7880

17 INFORMANT: Address: Betty Rogers, Aberdeen, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 2 mos

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 3-15-67, 19___, to May 23, 1967, that (I) (we) last saw the deceased alive on May 23, 1967, and that death occurred at 8:17 P.M. from causes and on the date stated above.

22a SIGNATURE: S J Plunkett Jr MD — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 5-24-67

22c PHYSICIAN'S NAME (Type): S.J. Plunkett Jr., M.D.

22d ADDRESS: 617 N. Bel Air Ave. Aberdeen, Md.

23a BURIAL CREMATION REMOVAL (Specify): Burial

23b DATE THEREOF: 26 May 67

23c NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens,

23d LOCATION (City or Town) (County) (State): Aberdeen, Maryland

24 FUNERAL DIRECTOR: Walter Macomber Jr. — ADDRESS: Tarrin Funeral Home Aberdeen, Md.

25a REC'D BY REGISTRAR DATE: MAY 26 1967

25b REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1 06752 ~~Item #1b,c,&d Film~~ 06753

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Harford, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): near Edgewood
c. LENGTH OF STAY IN 1b: 1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Mrs. Strong Nursing Home, Old Trenton Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: [illegible]
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): ~~[illegible]~~ / Towson
d. STREET ADDRESS: Shealey Ave. ~~[illegible]~~ / Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Edward [illegible] Steuart
4. DATE OF DEATH Month Day Year: May 4, 19[illegible]

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1 '3
9. AGE (in years last birthday): [illegible]3 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Engr. - ret.
10b. KIND OF BUSINESS OR INDUSTRY: General Institutions
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Richard S. Steuart
14. MOTHER'S MAIDEN NAME: Mary Tosley

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 1
16. SOCIAL SECURITY NO.
17. INFORMANT Address: F. il. records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic CV Disease
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 1-1, 1966, to 5-4, 19[illegible], that (I) ~~(we)~~ last saw the deceased alive on 4-1 1967, and that death occurred at 6 A M, from the causes and on the date stated above.

22a. SIGNATURE: Gerald C Palmer M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Gerald C. Palmer, M.D.
22d. ADDRESS: [illegible]

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: St. [illegible] Cemetery
23d. LOCATION (City, town or county) (State): Towson, Maryland

24. FUNERAL DIRECTOR ADDRESS: [illegible] Sons, Towson, Maryland
25a. REC'D BY REGISTRAR DATE: MAY 8 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06753 06740

1 PLACE OF DEATH
a COUNTY: Harford — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c LENGTH OF STAY IN 1b: 2 Hours
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a STATE: New Jersey — b COUNTY: Burlington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverside
d STREET ADDRESS: 512 Monroe Street
e IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: Patrick — Middle: J. — Last: STOER
4 DATE OF DEATH: Month: May — Day: 15 — Year: 19 67

5 SEX: Male
6. COLOR OR RACE: White
7 MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8 DATE OF BIRTH: August 30, 1947
9 AGE (Last birthday): 19 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10b KIND OF BUSINESS OR INDUSTRY: US Army
11 BIRTHPLACE (County & State or foreign country): Philadelphia, Pa.
12 CITIZEN OF WHAT COUNTRY?: USA

13 FATHER'S NAME: Benjamin Stoer
14. MOTHER'S MAIDEN NAME: Loretta McCay

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 12 Oct 66 - 16 May 67
16 SOCIAL SECURITY NO: 136-40-1755
17 INFORMANT — Address: DA 41 Personnel Records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Injuries to head
DUE TO
(b): intra-thoraccic organs and intra-abdominal organs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO
(c): Automobile Accident

INTERVAL BETWEEN ONSET AND DEATH: 3 Hours

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a ACCIDENT WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Deceased was the driver of an auto involved in an accident.
20c TIME OF INJURY Month, Day, Year — Hour a.m. / p.m.: 1:00 p.m. May 15 19 67
20d INJURY OCCURRED While at work [ ] Not While at work [X]
20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.): JFK Hwy Rte 95
20f (City or town) (County) (State): Whitemarsh, Baltimore, Md.

21. I certify that [X] (this hospital) attended the deceased from May 15, 19 67, to May 15, 19 67 that [XX] (we) last saw the deceased alive on May 15 19 67, and that death occurred at 4:00 A.M., from causes and on the date stated above.

22a SIGNATURE: Thomas Fraher MD — MD ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [XX]
22b DATE SIGNED: 15 May 1967
22c PHYSICIAN'S NAME (Type): THOMAS FRAHER, M.D.
22d ADDRESS: Kirk Army Hospital, APG, Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 19, 1967
23c NAME OF CEMETERY OR CREMATORY: Beverly National Cemetery
23d LOCATION (City or Town) (County) (State): Beverly, New Jersey

24 FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md.
25a RECD BY REGISTRAR — DATE: MAY 19 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

from the attending physician

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, with n 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06754

CERTIFICATE OF DEATH

06741

1 PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de Grace
c. LENGTH OF STAY IN 16: 3 days

2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: MARYland — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
d. STREET ADDRESS: 105 Ave D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hosp.

3 NAME OF DECEASED (Type or print): First: Posey — Middle: Drawer — Last: Sumpter

4 DATE OF DEATH: Month: MAY — Day: 12 — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 30, 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Aberdeen Prov. Gnd.
11. BIRTHPLACE (County & State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph G. Sumpter
14. MOTHER'S MAIDEN NAME: Martha Allie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO: 716-01-8655
17. INFORMANT — Address: Mrs. Maggie M. Sumpter, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO (b): Generalized Arteriosclerosis — 5 yrs
DUE TO (c): Acute Anemia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o'm. p.m. Month Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible] 19[illegible], to [illegible] 19[illegible] that (I) (we) last saw the deceased alive on May 12 1967 and that death occurred at 6:30 AM from causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5/15/67
22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD
22d. ADDRESS: DARLington Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City or Town) (County) (State): Port Deposit, Maryland.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Perryville, Maryland.

25a. RECD BY REGISTRAR — DATE: MAY 19 1967
25b. REGISTRAR'S SIGNATURE: [illegible] Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36755 — 05742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) — a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: N. Ridge Rd. R.D. #2 Box #14
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Lillian — Middle: C — Last: Teyhan
4 DATE OF DEATH: Month: 5 — Day: 31 — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐
8 DATE OF BIRTH: Feb 26, 1905
9 AGE (In years last birthday): 62 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Clerk
10b KIND OF BUSINESS OR INDUSTRY: Insurance
11 BIRTHPLACE (County & State or foreign country): Rodman, S. Carolina
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: John R. Culp
14 MOTHER'S MAIDEN NAME: Laura Alice Hefley

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 252-34-3981
17 INFORMANT: Husband 838-7668 — Address: Mr. William J. Teyhan — North Ridge Drive Rd #1 Box #14 Cedar Lane Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs
DUE TO (b): Coronary thrombosis — 4 hrs
DUE TO (c): Arteriosclerotic Cardiovascular disease — 34 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED: YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from May 24, 1967 to May 31, 1967 that (I) (we) last saw the deceased alive on May 31, 1967, and that death occurred at 9:40 A.M., from causes and on the date stated above

22a SIGNATURE: Edward C. Lee, M.D.
MD — ATTENDING PHYS ☒ — MED DIRECTOR ☐ — STAFF PHYS ☐
22b DATE SIGNED: 6/1/67
22c PHYSICIAN'S NAME (Type): Edward C. Lee, M.D.
22d ADDRESS: Maine St. Bel Air

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: June 2, 1967
23c NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d LOCATION (City or Town) (County) (State): Bel Air, Harford Co., Maryland 21014

24 FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a RECEIVED BY REGISTRAR — DATE: JUN 2 1967
25b REGISTRAR'S SIGNATURE: [illegible] Judge

VR A15 (4) 25M 1/67

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36756 — 06743

PLACE OF DEATH a. COUNTY: HARFORD — b. STATE: MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR (RURAL) — c. LENGTH OF STAY IN 1b: 18 YRS

c. NAME OF HOSPITAL OR INSTITUTION (If not in either, give street address): RD #2 Box 289 SHUCKS CORNER

2 USUAL RESIDENCE (Where deceased lived. If institution, give last residence): a. STATE: MARYLAND — b. COUNTY: HARFORD

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR (RURAL)

d. STREET ADDRESS: RD #2 Box 289

IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: RICHARD — Middle: COULSON — Last: TODD

4. DATE OF DEATH: Month: MAY — Day: 31 — Year: 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 23 Sep. 1904

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days Hours Min.: 62 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

11. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Perryville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: ROBERT TODD

14. MOTHER'S MAIDEN NAME: ~~XXXXXXXXX~~ Margaret Coulson ~~XXXXXXXX~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES

16. SOCIAL SECURITY NO.: 197-07-9737

17. INFORMANT: GRACE TODD (WIFE)

Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for a, b, and c.

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: LESS THAN 10 MIN.

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II as item 18)

20c. TIME OF INJURY Hour a.m. p.m. — Day — Year

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — City or town — County — State

21. I certify that I took charge of the remains described above held an Autopsy [ ] Inspection [X] Inquiry [X] and in my opinion Death resulted from Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Philip Heuman M.D M.D

EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D

CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town or county): 307 HICKORY AVE BEL AIR, Md

DATE SIGNED: 31 MAY 1967

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 13 June 67 — 22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens, — 22d. LOCATION City, town or country, State: Bel Air Maryland

23. FUNERAL DIRECTOR: Webster Macomber Sr. — ADDRESS: Tarring Funeral Home Aberdeen, Maryla.

24a. RECD BY REGISTRAR DATE: MAY 1967 — 24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9 6D

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

36757 — 06744

1. PLACE OF DEATH — a. COUNTY: Harford — 131 S. Union Ave — MARYLAND — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE — c. LENGTH OF STAY IN 1b: 3 YRS — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 131 So Union AVE.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) — a. STATE: Md — b. COUNTY: Harford — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE — d. STREET ADDRESS: 131 S. Union AVE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elijah — Middle: J. — Last: Vanover

4. DATE OF DEATH: Month: 5 — Day: 9 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-26-1904

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SETALINE BURNER OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: SHIPYARD

11. BIRTHPLACE (County & State, or foreign country): KENTUCKY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH G. VANOVER

14. MOTHER'S MAIDEN NAME: NANCY TOLLIVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 301-01-6459

17. INFORMANT: Mrs. Emeginia M. VANOVER — Address: HAVRE DE GRACE MD 21078

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Insufficiency — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Malignant Lymphoma

DUE TO

(c): Bronchogenic Carcinoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19 ..., that (I) (we) last saw the deceased alive on ..... 19....., and that death occurred at 10 25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Stephen Turbin — M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-11-67

22c. PHYSICIAN'S NAME (Type): STEPHEN TURBIN

22d. ADDRESS: 131 So Union Ave Havre de Grace Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE MEMORIAL PARK

23d. LOCATION (City, town or county): BALTO. CO. (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. MADISON MITCHELL, HAVRE DE GRACE, MD.

25a. REC'D BY REGISTRAR: MAY 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jagger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5 63

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the (undertaker) director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

36758 — 06745

1. PLACE OF DEATH
a. COUNTY: [illegible] — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Box 254A

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE:
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
d. STREET ADDRESS: Box 254A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last [illegible]

4. DATE OF DEATH: Month [illegible] Day [illegible] Year 19[illegible]

5. SEX: [illegible]

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: [illegible]

9. AGE (In years last birthday): [illegible] yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Private Family

11. BIRTHPLACE (County & State, or foreign country): [illegible]

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Glasco A. Davis

14. MOTHER'S MAIDEN NAME: Edna Willian.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-12-[illegible]

17. INFORMANT: My [illegible] Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Malignant hypertension — 15 yr.
DUE TO (c): Arteriosclerotic Cardiovascular disease — 15 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov, 19[illegible] to 12 May, 19[illegible], that (I) (we) last saw the deceased alive on 12 May 1967, and that death occurred at 5:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: Edwin W Whiteford Jr M.D — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 16 May 67

22c. PHYSICIAN'S NAME (Type): Edwin W. Whiteford Jr M.D

22d. ADDRESS: Whiteford Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: [illegible]

23c. NAME OF CEMETERY OR CREMATORY: [illegible]

23d. LOCATION (City, town or county) (State): [illegible]

24. FUNERAL DIRECTOR: [illegible] ADDRESS 556 [illegible]

25a. REC'D BY REGISTRAR DATE: MAY 18 1967

25b. REGISTRAR'S SIGNATURE: J Charles Goodwin

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06759 — 06746

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 51 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HENRY — Middle SCOTT — Last WHITE

4. DATE OF DEATH: Month MAY — Day 31 — Year 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 22 1874
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steam fitter Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (County & State, or foreign country): Penna. Lancaster Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William K. White
14. MOTHER'S MAIDEN NAME: Emma Jamison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-20-6426
17. INFORMANT: Address: Merton White Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac - Renal decompensation — INTERVAL BETWEEN ONSET AND DEATH: 24 h
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ASCVD — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/10, 1967, to 5/31, 1967, that (I) (we) last saw the deceased alive on 5/31 1967, and that death occurred at 5:30 A M, from causes and on the date stated above.

22a. SIGNATURE: A.W. Grigoleit — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/31/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-3-1967
23c. NAME OF CEMETERY OR CREMATORY: Rose Bank Cem
23d. LOCATION (City or Town) (County) (State): Colvert Cecil Md.

24. FUNERAL DIRECTOR: Lemon E. McMullen — ADDRESS: Rising Sun Md.
25a. REC'D BY REGISTRAR DATE: JUN 5 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

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20 M 1/66

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06760

CERTIFICATE OF DEATH

06747

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 42 Monroe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPHINE — Middle — Last WILLIS

4. DATE OF DEATH: Month May — Day 29 — Year 19 67

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 15 Aug. 1868

9. AGE (In years last birthday): 98 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Mozella Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-52-7886

17. INFORMANT — Address: Elsie W. Ames, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): C.V.A
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ASCVD

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MALNUTRITION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 7, 19 67 to May 29, 19 67 that (I) (we) last saw the deceased alive on May 29, 19 67, and that death occurred at 6:45 P.M. from causes and on the date stated above.

22a. SIGNATURE — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-31-67

22c. PHYSICIAN'S NAME (Type): Santiago Leyte-Vidal, M.D.

22d. ADDRESS: 114 W. Bel Air Ave. Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3 June 67

23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cemetery,

23d. LOCATION (City or Town) (County) (State): Aberdeen, Md.

24. FUNERAL DIRECTOR: Harry Carring — ADDRESS: Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR — DATE: JUN 2 1967

25b. REGISTRAR'S SIGNATURE: [illegible], Judge